Presbyterian HEALTHCARE

REQUEST FOR DELETION OF PRIVILEGE(S)

Name____Specialty___________________________
(Please print full name)

Please note that your request will be submitted to the Department Chair, Credentials Committee, Medical Board and Board of Trustees for action. In the event you wish to obtain these privileges in the future, you will need to reapply and must satisfy any required credentialing criteria in place at that time. You must explain the reason for your request. Please note that you may not delete privileges to avoid on-call responsibilities.

❑ I am requesting that the following privileges be deleted: ______________________________________

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Please describe in detail the basis for your request explaining your reason:

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❑ This request applies to privileges at the following facilities:

- ❑ Presbyterian Hospital Main/POH
- ❑ Presbyterian Hospital Matthews
- ❑ Presbyterian Hospital Huntersville
- ❑ South Park Surgery Center
- ❑ Ballantyne Surgery Center
- ❑ Monroe Surgery Center

SIGNATURE: ______________________________________ **DATE:** _____________________________

Fax form to (704) 417-4279 or mail to Credentialing Manager, Medical Staff Services:
Presbyterian Hospital • 200 Hawthorne Lane • Post Office Box 33549 • Charlotte, NC 28233-3549

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